IN THE

Supreme Court of the United States

OCTOBER TERM, 1979

No. 79-92

LINCOLN PARK NURSING HOME, LINCOLN PARK NURSING AND CONVALESCENT HOME, INC., ANDOVER NURSING HOME, INC. and ANDOVER NURSING AND CONVALESCENT HOME, INC.,

Petitioners,

vs.

THE UNITED STATES,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

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Petitioners,

vs.

THE UNITED STATES,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

Petitioners pray that a writ of certiorari issue to review the judgment and opinion of the United States Court of Claims entered in this proceeding on April 20, 1979

Opinions Below

The opinion of the United States Court of Claims is appended to this petition as Appendix A. It is as yet unreported.

Jurisdiction

The judgment and opinion of the Court of Claims was filed on April 20, 1979. The Jurisdiction of the Court is, therefore, invoked under 28 U.S.C. 1255(1) to review a judgment of the Court of Claims by issuance.

Questions Presented

1. Is Medicare regulation 20 C.F.R. 405.415(d)(3), as applied by the Government by administrative interpretive rule to petitioners, to recapture reimbursements for depreciation charges taken by petitioners up to 3 years and 2 months prior to the effective date of such regulation, unconstitutional under the due process clause of the Fifth Amendment of the United States Constitution?

2. Is Medicare regulation 20 C.F.R. 405.415(d)(3), contrary to statutory design or unconstitutional under the due process clause of the Fifth Amendment of the United States Constitution?

Statement of the Case

The jurisdiction of the Court of Claims was invoked under 28 U.S.C. Sect. 1491 (the Tucker Act) because of petitioners' contract with the Government and also because the Medicare legislation mandates appropriate payment to

providers, i.e. such as petitioners herein. Petitioners had previously filed suit, Civil Action No. 74-1431, in the United States District Court for the District of New Jersey, on September 18th, 1974, alleging the same cause of action later presented to the Court of Claims. Because plaintiffs' actions commenced before direct appeals to the United States District Courts were permitted by statute (Sect. 1878(f)(1) of the Social Security Act, 42 U.S.C. 1395oo) said suit was dismissed by the District Court for lack of jurisdiction without prejudice to plaintiffs' right to bring suit in the Court of Claims. The Third Circuit affirmed the District Court's jurisdictional decision on May 4, 1978.

This case arises out of an action brought by petitioner challenging on Constitutional grounds (Fifth Amendment of the United States Constitution) the application to it by the Government of a Medicare regulation, 20 C.F.R. 405.415(d)(3) effective date August 1, 1970, by virtue of which the Government recaptured some $186,191.00 of accelerated depreciation legally taken by petitioner in the years June 1, 1967 to June 1, 1970 under a previous regulation, 20 C.F.R. 405.415 (1967).

Pursuant to regulations promulgated by the Secretary (Sect. 405.415(a) (1967), Bureau of Health Insurance, Department of Health, Education and Welfare), petitioners were permitted to determine depreciation for purposes of reimbursement under the Medicare program using the double declining balance method of accounting.

The Secretary promulgated the above regulation at the inception of the Medicare program in order to attract providers such as plaintiffs into the program. The Medicare program does not permit any profit so that the only incentive to a provider to enter the program was the advantage of accelerated depreciation and a percentage return on the petitioners' own investment. The Secretary offered this

as a consideration to petitioners to enter its contract and the right to that consideration vested at the time the contract was entered into between the parties.

On or about August 1, 1970, the Secretary adopted a new regulation (Sect. 405.415(d)(3) of Bureau of Health Insurance Regulations of the Department of Health, Education and Welfare) which provides the following:

> "(3) When a provider who has used an accelerated method of depreciation with respect to any of its assets terminates participation in the program, or where the health insurance proportion of its allowable costs decreases so that cumulatively substantially more depreciation was paid than would have been paid using the straight-line method of depreciation, the excess of reimbursable cost, determined by using accelerated depreciation methods and paid under the program over the reimbursable cost which would have been determined and paid under the program by using the straight-line method of depreciation will be recovered as an offset to current reimbursement due or, if the provider has terminated participation in the program, as an overpayment. In this determination of excess payment, recognition will be given to the effects the adjustment to straight-line depreciation would have on the return on equity capital and on the allowance in lieu of specific recognition of other costs in the respective years."

At the time the recapture regulation was promulgated, the respondent's intermediary, Blue Cross, administered the contract between Lincoln Park Nursing and Convalescent Home, Inc. and the intermediary in such a fashion as to prejudice the business of the nursing home; to make it impossible to carry on the business of the nursing home efficiently and properly. For example, the intermediary

would, as much as a year later in time, disallow reimbursement of Medicare patients. Since these monies had already been spent on the patients, it meant that the petitioners would have to make this money up out of their own pockets since in a large number of cases the patients had already passed away or disappeared. This dislocated the economics of running the nursing homes. The input from the intermediary to the plaintiffs with respect to "guide-lines" and the determination of the costs was so vague as to make bookkeeping virtually impossible at times. Lastly, and most important, the intermediary, during the latter part of 1969, dictated that the utilization committee which determines the length of time the patient stays in the home, cut the length of stay to the "bone" and if they did not do so, the intermediary would not recognize the cost. From that point on, there was less Medicare utilization because of the time gap in replacing one patient with another after a stay was terminated. As a consequence, there was a slight decrease in Medicare patients during the course of the year 1970, a trend which increased in 1971. In short, any subsequent decrease in the petitioner's participation in the Medicare program was the result of the Government's own acts.

Subsequently, in May, 1972, the HEW Provider Reimbursement Manual, which interprets and elaborates upon the Medicare regulations, was revised in a number of respects. It announced that the new regulation regarding the recapture of accelerated depreciation would be applied retroactively to recover excess reimbursements received by providers during fiscal periods prior to 1970, the year of the new enactment. Second, the Manual made the recapture provision inapplicable to those providers that severed their relationship with the Medicare program effective before August 1, 1970. Third, the Manual explained that for purposes of the recapture rule, a substantial decrease in

Medicare utilization occurs "where the provider's ratio of health insurance days to total in-patient days . . . has decreased 25 per cent or more from the base period to the computation period". The Manual provisions enunciate HEW guidelines and policies for implementing the Medicare regulations but are not issued in accordance with the procedures specified in the Administrative Procedure Act and admittedly do "not have the effect of regulations". Defendant applied the recapture regulations and compelled petitioners to repay in cash $186,191.00 for the years prior to the adoption of the regulation. These monies were being utilized by the provider as working capital in the running of the homes. The dislocation the take-back of these monies caused, was nearly catastrophic, and the homes bordered on the verge of bankruptcy; payables ran as much as 180 days late to trade creditors, anyone of which could have put the home in receivership. Petitioners were forced to borrow large sums of money at high rates of interest to get by. Despite this, petitioners have stayed in the Medicare program and are active in it.

The decision of the Court of Claims was on the Government's motion for summary judgment. In a succinct disposition of the constitutional controversy, the Court held:

> "Plaintiffs claim that this regulation, providing for the retroactive recapture of excess accelerated depreciation, is contrary to the Medicare Act and is unconstitutional in that it contravenes the due process clause of the Fifth Amendment. Plaintiffs also argue that the regulation was improperly applied to them because the decline in Medicare use of their services occurred through no fault of their own.
>
> "This court considered and rejected all of these arguments *in Summit Nursing Home, Inc.* v. *United States,* 215 Ct.Cl. ——, 572 F.2d 737 (1978). In concluding that the retroactive application of the regulation did not transgress constitutional guarantees, we explained:
>
> > (T)he Secretary determined, in the regulation, that when a substantial decrease in the utilization of plaintiff's facilities by Medicare patients occurred, a continued allowance of accelerated depreciation at the rate previously approved would result in a situation where the non-Medicare patients would get the benefit of expenditures made solely for the benefit of Medicare patients. In view of the explicit statutory obligation imposed on the Secretary (to ensure that the Medicare program not pay costs of non-Medicare patients, 42 U.S.C. Sect. 1395x(v)(1)(A)(i)), we cannot say that the retroactive recapture here was such an unreasonable or oppressive application of the regulation that it constituted a denial of due process.
>
> *Id.* at ——, 572 F.2d at 744.
>
> "*Plaintiffs ask us to depart from the ruling in Summit Nursing Home, Inc., and to adopt instead the reasoning of the Third Circuit which recently refused to apply the same regulation retroactively to a case which seems to be on all fours with Summit and the present one.* (Emphasis supplied) *Daughters of Miriam Center for the Aged* v. *Mathews,* 3rd Cir., No. 78-1050, decided December 29, 1978. However, under the settled practice of this court this panel cannot overrule or disregard the decision of another panel even if we have the disposition to do so; only the court *en banc* can do that. See *Dravo Corp.* v. *United States,* Ct. Cl. No. 315.77 decided

February 21, 1979, slip op., p. 2. Accordingly, in view of Summit Nursing Home we must grant the Government's motion for summary judgment on plaintiffs' accelerated depreciation claim."

The Third Circuit's decision in *Daughters of Miriam, supra,* is appended to this petition as Appendix B. That decision is diametrically opposite to that of the Court of Claims. Nor has the Government appealed same.

REASONS FOR GRANTING THE WRIT

The issues presented are substantial and far reaching. Their adjudication in the various federal courts has resulted in a direct conflict between decisions of the United States Court of Claims and a decision of the United States Court of Appeals for the Third Circuit and, therefore, this court's guidance is required in the interest of the effective administration of justice. In addition, an important question of federal and constitutional law which has been litigated in several federal circuits, 1st, 2nd, 3rd, 4th, 5th, 7th and 9th, has not been, but should be, settled by this court.

The petition presents several issues of substantial importance and far reaching effect involving the following: a federal court's rejection of interpretive rule-making by the Department of HEW; the parameters of the court's mandate in reviewing and deciding the efficacy of administrative rulemaking; the efficacy of the *Daughters of Miriam* decision as a correct current application of this Court's decision in *Skidmore* v. *Swift & Co.,* 323 U.S. 134, 140 (1944), *United States* v. *Pennsylvania Industrial Chemical Corp.,* 411 U.S. 655, 674 (1973), *General Electric* v. *Gilbert,* 429 U.S. 125, 140-145 (1976) in the context of the

testing the retroactive application by HEW of a regulation whose efficacy and application has been litigated in at least seven circuits as opposed to the decision contra, of the United States Court of Claims.

The Third Court of Appeals in *Daughters of Miriam, supra,* held (at p. 15):

> ". . . we note that the administrative agency here has no particular expertise concerning the issue of retroactivity. To the contrary, the extent to which retroactive effect may be given to a promulgation is governed by principles of law that have been developed and refined by the courts, primarily in the context of constitutional adjudication. Accordingly, we now examine such principles to determine whether the depreciation recapture regulation should be given retroactive effect in the present case. Because we shall conclude that retroactive application to the Center of the depreciation recapture regulation is incompatible with such principles, we shall exercise the prerogative that we have when reviewing interpretative rules and refrain in the present case from giving the regulation the retroactive effect contemplated by the manual provision."

The factual pattern, almost identical to that *sub judice* decided the court in favor of the provider and against the Government's retroactive application. In so doing, the court cited (at p. 15):

> "See, e.g., *Usery* v. *Turner Elkhorn Mining Co.,* 428 U.S. 1, 16-17, 96 S. Ct. 2882, 2893, 49 L.Ed.2d 752 (1976):
>
> 'It does not follow, however, that what Congress can legislate prospectively it can legislate retrospectively. The retrospective aspects of legislation, as

well as the prospective aspects, must meet the test of due process, and the justifications for the latter may not suffice for the former.' "

(At p. 16)

"*Adams Nursing Home of Williamstown, Inc.* v. *Mathews,* 548 F.2d 1077, 1080 (1st Cir. 1977). See also *SEC* v. *Chenery Corp.,* 332 U.S. 194, 203 67 S. Ct. 1575, 1581, 91 L.Ed. 1995 (1947):

'(S)uch retroactivity must be balanced against the mischief of producing a result which is contrary to a statutory design or to legal and equitable principles. If that mischief is greater than the ill effect of the retroactive application of a new standard, it is not the type of retroactivity which is condemned by law.'

"Although the language used by the Supreme Court to describe its approach to retroactive enactments has varied from case to case, the commentators have concluded that the common thread underlying the decisions has been the balancing of considerations on both sides of the issue. See Hochman, *The Supreme Court and the Constitutionality of Retroactive Legislation,* 73 Harv.L.Rev. 692 (1960); Slawson, *Constitutional and Legislative Considerations in Retroactive Lawmaking,* 48 Calif. L.Rev. 216 (1960)."

Did the Third Circuit correctly analyze and apply the cases decided by this Court cited aforesaid? Petitioner urges an affirmative answer to this question. Obviously the judges sitting in the Court of Claims did not think so. This Court should resolve that conflict.

Lastly, the statutory and constitutional validity of the regulation itself, 20 C.F.R. Sect. 405.415, has been widely litigated and has resulted in two opposite lines of decision.

The Government's view is supported by *Springdale Convalescent Center* v. *Mathews,* 545 F.2d 943 (5th Cir. 1977); *Adams Nursing Home, Inc.* v. *Mathews,* 548 F.2d 1077 (1st Cir. 1977); *Hazelwood Chronic & Convalescent Hosp., Inc.* v. *Weinberger,* 543 F.2d 703 (9th Cir. 1976) vacated and remanded on other grounds, 430 U.S. 952, 97 S.Ct. 1595, 51 L.Ed. 2d 801 (1977).

Petitioners views are supported by the following district courts decisions: *Hazelwood Chronic & Convalescent Hospital, Inc.* v. *Weinberger,* C.A. No. 73-210 (D.Or. 1974), rev'd, 543 F.2d 703 (1976); *South Windsor Convalescent Home, Inc.* v. *Weinberger,* 403 F.Supp. 515 (D.Conn. 1975) rev'd. for lack of jurisdiction, 541 F.2d 910 (2d Cir. 1976); *Columbia Heights Nursing Home, Inc.* v. *Weinberger,* 380 F. Supp. 1066 (M.D.La. 1974); *Mt. Sinai Hospital of Greater Miami, Inc.* v. *Weinberger,* 376 F. Supp. 1099 (S.D. Fla. 1974), rev'd, 517 F.2d 329 (5th Cir. 1975), and *Fairfax Nursing Center, Inc.* v. *Califano,* C.A. No. 77-83-A (E.D. Va. June 2, 1977), appeal filed 4th Cir. July 22, 1977.

This Court should finally resolve the issue.

CONCLUSION

For the foregoing reasons, it is respectfully submitted that this petition for a writ of certiorari to the United States Court of Claims should be granted.

Respectfully submitted,

DAVID A. BIEDERMAN
Counsel for Petitioners

[APPENDICES FOLLOW]

APPENDIX A

Opinion and Order of the United States Court of Claims

(Filed—April 20, 1979)

IN THE UNITED STATES COURT OF CLAIMS

No. 437-77

LINCOLN PARK NURSING HOME, LINCOLN PARK NURSING AND CONVALESCENT HOME, INC., ANDOVER NURSING HOME AND ANDOVER NURSING AND CONVALESCENT HOME, INC. v. THE UNITED STATES	Medicare providers; recapture of accelerated depreciation; owners' compensation; physical therapy costs.

David A. Biederman, attorney of record, for plaintiffs.

Sandra P. Spooner, with whom was *Assistant Attorney General Barbara Allen Babcock,* for defendant. *Barbara Spevak,* of counsel.

Before FRIEDMAN, *Chief Judge,* DAVIS and KASHIWA, *Judges.*

Appendix A

ORDER

This case comes before the court on defendant's motion for summary judgment, filed August 31, 1978. In the absence of any indication of opposition from plaintiffs, the court initially issued a "speaking" order on November 17, 1978 (without oral argument) granting defendant's motion. Thereafter, on plaintiffs' counsel's assertion that his office had never received defendant's motion, the court vacated (on January 26, 1979) its earlier order. Plaintiffs then filed an opposition to defendant's motion, and the case is now ready for disposition (again without oral argument).

Plaintiffs, New Jersey corporations which are providers of services under the Medicare provisions of the Social Security Act,[1] challenge as unconstitutional and without statutory authority the Medicare regulation providing for the recapture of excess accelerated depreciation reimbursements in cases where the provider has terminated or substantially decreased its participation in the Medicare Program.[2] Plaintiffs also challenge certain disallowances of owner's compensation and physical therapy costs.

Since January 1, 1967, plaintiff Lincoln Park Convalescent Home, Inc. has provided nursing services to the public on property owned by plaintiff Lincoln Park Nursing Home. Since the same date, plaintiff Andover Nursing and Convalescent Home, Inc. similarly has provided nurs-

[1] 42 U.S.C. §1395 *et seq.* (1970), hereinafter referred to as the "Medicare Act."

[2] 20 C.F.R. 405.415(d)(3)(1970). This regulation is now to be found in Title 42, Part 405 of the Code of Federal Regulations. *See* 42 Fed. Reg. 52,826 (1977).

Appendix A

ing services to the public on property owned by plaintiff Andover Nursing Home. Each pair of corporations (hereinafter referred to as "Lincoln Park" and "Andover" respectively) forms a single "provider" of services under the Medicare Program, 42 U.S.C. §1395x(u), entitling each to reimbursement from the Government for reasonable costs incurred in extending nursing services to Medicare beneficiaries. 42 U.S.C. §1395f(b). Plaintiffs nominated Blue Cross Association (BCA) and its local administering agent Hospital Service Plan of New Jersey (Plan) to act as their fiscal intermediaries.[3]

In 1973, the Plan determined that plaintiffs had been overpaid for fiscal years 1967 through 1971 and proceeded to deduct appropriate amounts from their current reimbursements. Plaintiffs challenged three of the adjustments made by the Plan, specifically (1) its adjustment to recapture the difference between straight-line depreciation and the accelerated depreciation Lincoln Park had claimed as a reimbursement cost, (2) the Plan's refusal to allow certain sums to be paid as compensation to the owners of Lincoln Park and Andover, and (3) the Plan's disallowance of costs for physical therapy services claimed by Lincoln Park. Plaintiffs appealed these determinations to the Blue Cross Association Provider's Appeals Committee (Committee), a review board established by the BCA to hear and decide appeals from providers who, like plaintiffs, are not content with a decision of their fiscal intermediary. Two separate hearings were held, one on May 2, 1973, which was limited to the disallowance of costs for

[3] A fiscal intermediary is a public agnecy or private organization which contracts with the Secretary of Health, Education, and Welfare, under 42 U.S.C. §1395h(a), to determine the amount of reimbursement to be paid to providers and to make the payments.

owner's compensation for the years 1967 and 1968, and the other on May 15, 1974 which encompassed all of plaintiffs remaining disputes. In each case, the Committee affirmed the Plan's determinations as to properly reimbursable costs. Plaintiffs have thus exhausted their administrative remedies.[4]

Plaintiffs' first claim before this court involves a challenge to the constitutional validity and statutory authority of the Medicare regulation requiring recapture of excess accelerated depreciation when the provider has terminated or substantially decreased its participation in the Medicare program. From 1966 until August 1, 1970, a Medicare regulation gave providers the opportunity to claim accelerated depreciation on capital assets as a reimbursable cost. 20 C.F.R. §405.415 (1967). Until 1970, plaintiffs exercised their option to claim accelerated depreciation.

On August 1, 1970, a proposed Medicare regulation was adopted, effective the same date, which provided, in relevant part, that when a provider terminated its participation in the Medicare program or when there had been a substantial decline in use of the provider's services by Medicare patients, the Secretary of the Department of Health, Education and Welfare could recover as an offset to current reimbursements due "the excess reimbursable cost, determined by using accelerated depreciation methods and paid under the program over the reimbursable cost

[4] Plaintiffs filed suit in United States District Court for the District of New Jersey on September 18, 1974 alleging the same cause of action presented here. That suit, Civil Action No. 74-1431, was dismissed for lack of jurisdiction without prejudice to plaintiffs' right to bring suit in the Court of Claims. The Third Circuit affirmed the District Court's decision on May 4, 1978.

which would have been determined and paid under the program by using the straight-line method of depreciation."[5] Plaintiffs claim that this regulation, providing for the retroactive recapture of excess accelerated depreciation, is contrary to the Medicare Act and is unconstitutional in that it contravenes the due process clause of the Fifth Amendment. Plaintiffs also argue that the regulation was improperly applied to them because the decline in Medicare use of their services occurred through no fault of their own.

This court considered and rejected all of these arguments in *Summit Nursing Home, Inc.* v. *United States,* 215 Ct. Cl. ——, 572 F. 2d 737 (1978). In concluding that the retroactive application of the regulation did not transgress constitutional guarantees, we explained:

> [T]he Secretary determined, in the regulation, that when a substantial decrease in the utilization of plaintiff's facilities by Medicare patients occurred, a continued allowance of accelerated depreciation at the rate previously approved would result in a situation where the non-Medicare patients would get the benefit of expenditures made solely for the benefit of Medicare patients. In view of the explicit statutory obligation imposed on the Secretary [to ensure that the Medicare program not pay costs of non-Medicare patients, 42 U.S.C. §1395x(v)(1)(A)(i)], we cannot say that the retroactive recapture here was such an unreasonable or oppressive application of the regulation that it constituted a denial of due process.

Id. at ——, 572 F.2d at 744.

[5] 20 C.F.R. § 405, 415 (d)(3) (1970).

Plaintiffs ask us to depart from the ruling in *Summit Nursing Home, Inc.*, and to adopt instead the reasoning of the Third Circuit which recently refused to apply the same regulation retroactively to a case which seems to be on all fours with Summit and the present one. *Daughters of Miriam Center for the Aged* v. *Mathews,* 3rd Cir., No. 78-1050, decided December 29, 1978. However, under the settled practice of this court this panel cannot overrule or disregard the decision of another panel even if we have the disposition to do so; only the court *en banc* can do that. *See Dravo Corp.* v. *United States,* Ct. Cl. No. 315-77, decided February 21, 1979, slip op., p. 2. Accordingly, in view of *Summit Nursing Home* we must grant the Government's motion for summary judgment on plaintiffs' accelerated depreciation claim.

Plaintiffs' second and third claims require this court to review the administrative determinations of the Plan with respect to disallowances for owner's compensation and physical therapy services. On appeal, these disallowances were upheld by the Committee.

It is by now settled that this court has a limited scope of review over such claims in Medicare cases. As we said in *Gosman* v. *United States,* 215 Ct. Cl. ——, 573 F.2d 31, 34 (1978):

> the decisions of the Hearing Panel are to be examined for compliance with the Constitution, statutory provisions, and regulations having the force and effect of law, as well as for the taint of arbitrariness, capriciousness, or lack of support in substantial evidence.

See also St. Elizabeth Hospital v. *United States,* 214 Ct. Cl. 322, 326-27, 558 F.2d 8, 11-12 (1977); *Overlook Nursing Home, Inc.* v. *United States,* 214 Ct. Cl. 60, 65, 556 F. 2d 500, 502 (1977); *Whitecliff, Inc.* v. *United States,* 210 Ct. Cl. 53, 56-58, 536 F.2d 347 349-51 (1976), *cert. denied,* 430 U.S. 969 (1977). Plaintiffs summarily attack the procedural fairness of the hearings before the Appeals Committee but do not list any information they could not present, or show with any specificity at all that they were in fact deprived of a fair opportunity to present their viewpoint or to answer the Plan's contentions. In these circumstances, there is no ground on which we can order a further administrative hearing or direct a trial de novo in this court. *Cf. Goldstein* v. *United States,* 201 Ct. Cl. 888, *cert. denied,* 414 U.S. 974 (1973). The administrative record will be accepted as the basis for our review.

Both Lincoln Park and Andover nursing homes were owned and operated by corporations which were solely owned by Mr. and Mrs. Jerry Turco. Mr. Turco was the executive director of the two homes, while his wife held the position of executive administrator. From 1967 to 1971, Mr. and Mrs. Turco claimed certain sums representing compensation for their personal services as reimbursable costs under Medicare regulation 20 C.F.R. §405.426 (1966).[6] A portion of these sums was disallowed by the Plan and the Committee as unreasonable.

Plaintiffs specifically challenge the Plan's complete disallowance of owners' compensation to Jerry Turco and its partial disallowance of compensation to Mrs. Dolores Tur-

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[6] Redesignated at 42 Fed. Reg. 52,826 (1977) as 42 C.F.R. §405.426.

co.[7] The Plan's refusal to permit any compensation to be paid to Mr. Turco was based on findings that he was employed full-time in a construction and paving business unrelated to the nursing homes and that any services he performed for the homes were in the nature of overseeing his investment. We find this determination to be fully supported by the record, particularly in view of evidence in the record that Mr. Turco's interest in Lincoln Park and Andover was strictly financial and that he did not actively participate in the operation of the nursing homes.

We also find the partial disallowance to Mrs. Turco to be fully supported by the record and to be neither arbitrary nor capricious. The Plan based its decision on guidelines prepared by the Bureau of Health Insurance specifying the range of reasonable compensation for owner-administrators, based upon bed size of the facility. Mrs. Turco was allowed a compensation approximately equal to one-half the top salary in the range for a 150-bed nursing home for each of the two facilities. This decision was entirely reasonable since Lincoln Park and Andover each had 150 beds and Mrs. Turco, employed full-time by the nursing homes, divided her time equally between the two. Given this and the fact that the record shows that the nursing homes had full-time salaried administrators other than Mrs. Turco, we cannot say that the Plan's decision to disallow a portion of her claimed owner's compensation was arbitrary or capricious or unsupported by the evidence.

[7] Plaintiffs also seek review of Lincoln Park's claim for owners' compensation representing salary to both Mr. and Mrs. Turco for the six-month period ending June 30, 1967, which was disallowed because the sum, although listed as accrued in Lincoln Park's books, was not actually paid to the owners during that period, as required by 20 C.F.R. §405.426(d)(2). This determination is supported by substantial evidence.

Plaintiffs' brief in opposition to the defendant's motion for summary judgment contains several general and non-specific statements as to the alleged contributions of Mr. and Mrs. Turco to the administration and management of the homes—supported only by short conclusory affidavits by Mr. and Mrs. Turco that the briefs' statement of facts concerning their compensation is true. We are given no adequate reason why this purportedly factual information was not furnished to the Appeals Committee, but in any event the general statements now made do not deprive the Committee's determination of the support of substantial evidence or render it arbitrary or capricious.

Plaintiffs' third claim is a challenge to the Plan's decision to reimburse Lincoln Park at the rate of $4.00 per treatment, rather than $6.00 per treatment, for physical therapy services rendered by one Steven Frank in 1969 and 1970. The Plan disallowed any reimbursement in excess of $4.00 per treatment based on 1971 guidelines for reasonable costs of physical therapy services established by the Bureau of Health Insurance in conjunction with the American Physical Therapy Association.[8]

Plaintiffs assert that the retroactive application of these 1971 guidelines to a previously negotiated contract for services performed in 1969 and 1970 is a violation of the due process clause of the Fifth Amendment. We do not agree. In promulgating these guidelines, the Bureau of Health Insurance was doing no more than fulfilling its

[8] These guidelines established that a fee of $15.00 per hour or $4.00 per treatment, whichever was less, was reasonable compensation for rotational physical therapy.

statutory mandate to ensure that services rendered to Medicare beneficiaries do not exceed their reasonable cost. 20 C.F.R. §405.451 (1966). The Bureau defines reasonable cost in terms of that which the "prudent buyer" would pay. Specifically, "[t]he prudent and cost-conscious buyer not only refuses to pay more than the going price for an item or service, he also seeks to economize by minimizing cost." Provider Reimbursement Manual, HIM-15, §2103. Among the methods permitted intermediaries to determine excess costs is "comparing the prices paid for similar items or services by comparable purchasers. . . ." *Id.* This is precisely what the Bureau did in establishing the reasonable fee schedule for physical therapy services. Since the Plan was under a statutory obligation to deny plaintiffs' excessive costs, we cannot say that the application of the 1971 fee schedule to plaintiffs' contract with Mr. Frank was so unreasonable as to violate due process.

Nor was the Plan's decision arbitrary or capricious or unsupported by substantial evidence. In denying the excess reimbursement, the Plan was fulfilling its regulatory duty to exclude excessive costs from reimbursable amounts in cases where a provider can show no clear justification for paying more than the going rate for physical therapy services. Provider Reimbursement Manual, HIM-15 §2103. The record reveals no offered justification for the premium, other than the plaintiffs' assertions that the agreement between Mr. Frank and Lincoln Park was negotiated in good faith, at arm's length and with no intent to defraud the Government, and that Mr. Frank charged non-Medicare patients at the same rate as Medicare patients. There was no adequate evidence that plaintiffs attempted unsuccessfully to hire a physical therapist at a rate lower than $6.00 per treatment, or that Mr. Frank's particular talents jus-

tified the premium.[9] On the whole, we cannot find the decision of the Plan, affirmed by the Committee, to be arbitrary, capricious or unsupported by the evidence.

IT IS THEREFORE ORDERED, for the reasons stated above, that defendant's motion for summary judgment be granted. The petition is dismissed.

BY THE COURT

s/ DANIEL M. FRIEDMAN
Chief Judge

[9] In their brief in opposition to defendant's motion, plaintiffs assert that (a) Mr. Frank has sworn that no one to his knowledge charged less than $6.00 per treatment in the geographical area, and (b) plaintiffs were unsuccessful in attempts to obtain a salaried in-house physical therapist (this latter statement is unsupported by any affidavit). *Again, no reason is given why this information could not have been supplied to the Committee in specific and verified form; also, we cannot now say that it would or should have made a difference in the determination.*

APPENDIX B

Opinion of the United States Court of Appeals for the Third Circuit *(Re: Daughters of Miriam Center for the Aged* v. *Matthews, David, et al.)*

UNITED STATES COURT OF APPEALS

FOR THE THIRD CIRCUIT

No. 78-1050

DAUGHTERS OF MIRIAM CENTER FOR THE AGED,
A Non-Profit Corporation of the State of New Jersey,
Appellant

v.

MATTHEWS, DAVID, *et al.*, Secretary of Health, Education and Welfare; and BLUE CROSS ASSOCIATION/HOSPITAL SERVICE PLAN OF NEW JERSEY

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

(D.C. Civil No. 77-0054)

Argued September 7, 1978
Before SEITZ, *Chief Judge,* ADAMS and ROSENN,
Circuit Judges

Appendix B

(Opinion filed December 29, 1978)

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OPINION OF THE COURT

ADAMS, *Circuit Judge.*

When Congress establishes a program to aid a particular segment of the population, if often perceives a need and envisions a goal, but as a practical matter cannot sketch the intricate details for implementing its plan. In such cases, the task of administration is frequently delegated to an agency which is directed to develop necessary rules in light of experience. To ensure the fullest possible attainment of the legislative directives, the agency occasionally must modify its regulations to meet changing circumstances. These curative measures usually are treated

deferentially by the courts, even when they upset the expectations of private parties. But sometimes, and particularly when a modification is applied retroactively, a corrective rule is found to sweep too broadly, abridging statutory authorization, exceeding the scope of a controlling rule, or even violating constitutional rights.

On this appeal, we must determine whether a curative change in the portion of the Medicare regulations dealing with nursing homes is to be applied retroactively in the factual situation presented here. Nursing homes that provide services to Medicare beneficiaries are reimbursed for their "reasonable cost" in providing such services, including the expense of acquiring their capital assets, as prorated over the useful lives of such assets. Initially, the governing regulations permitted nursing homes to prorate the expense of their assets under either straight-line or accelerated methods of depreciation. To eliminate certain abuses, however, the regulations were amended in 1970 to require that the government recapture from any provider that abandons the program or that experiences a substantial decrease in utilization by Medicare patients the excess reimbursement that resulted from the provider having depreciated its assets under an accelerated rather than the straight-line method. By administrative fiat, such amendment was given retroactive as well as prospective effect.

Daughters of Miriam Center for the Aged (the Center) experienced a substantial decrease in utilization by Medicare patients within the meaning of the new regulation during 1973, so the Secretary of Health, Education and Welfare (Secretary), who supervises the Medicare program, ordered the recapture from it of $148,324—the difference between accelerated and straight-line depreciation for the previous six years. The Center challenged, on

statutory and constitutional grounds, the application to it of the depreciation recapture regulation, but was denied relief in the district court. Because we disagree with HEW's position that retroactive application to the Center of such regulation so as to permit recovery of excess reimbursements for years prior to 1970 is consistent with the purpose underlying such regulation, that portion of the judgment that is based upon retroactive application of the recapture regulations will be reversed.

I.

Under the Medicare Act, 42 U.S.C. § 1395 *et seq.*, hospitals, nursing homes, and similar-type facilities that are providers of services to Medicare patients generally may not charge such patients directly for the services provided. 42 U.S.C. § 1395cc(a)(1). Instead, the Secretary of HEW, usually through designated fiscal intermediaries, reimburses each provider for the "reasonable cost" incurred by it in rendering such care. 42 U.S.C. §§ 1395f(b), 1395h. The provider is reimbursed periodically, though not less often than monthly, for its estimated expenses, based on billings submitted to the Secretary or his designated fiscal intermediary. At the close of the fiscal year, the provider submits a cost report, and the Secretary then determines by audit the amount of reimbursement to which the provider is entitled for that period. Adjustments are thereafter made in the current periodic payments so that the actual reimbursement for the year coincides with the amount due under the audit. 42 U.S.C. § 1395g.

Recognizing that health facilities use a variety of methods to determine patient charges and the expenses of rendering care, Congress refrained from specifying the

method to be used for calculating "reasonable cost." Rather, in 42 U.S.C. § 1395x(v)(1)(A),[1] Congress delegated to the Secretary of HEW the responsibility for promulgating regulations that establish the methods to be adopted and the items to be included in the determination of "reasonable cost." Although the Secretary is given considerable leeway in fashioning the regulations, he is instructed that "reasonable cost" is to reflect the cost "actually incurred" in supplying the services, so that the cost of delivering services to Medicare patients will not be imposed on the provider's other patients, and the cost of caring for non-Medicare patients will not be borne by the Medicare program. The section also states that the regulations are to

[1] 42 U.S.C. § 1395x(v)(1)(A) provides, in pertinent part:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used and the items to be included in determining such costs for various types or classes of institutions, agencies, and services . . . . Such regulations shall (i) take into account both direct and indirect costs of providers of services . . . in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

> provide for the making of suitable retroactive corrective adjustments where, for a provider of services of any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

In a more general vein, Congress declared in 42 U.S.C. § 1395hh that "[t]he Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter."

Exercising the authority vested in him, the Secretary published regulations defining and governing the methods and formulas for determining "reasonable cost." Initially, the regulations permitted providers to include as a "reasonable cost" item the depreciation of their capital assets as computed either under the straight-line method or under one of two accelerated depreciation methods.[2] Experience

[2] 20 C.F.R. § 405.415 (1967). Straight-line depreciation requires an even allocation of the cost of a capital asset, less its salvage value, over its useful life. Accelerated depreciation allocates more of the cost of a capital asset to the early years of the asset's useful life, and less to its later years. Declining balance and sum-of-the-years' digits methods of accelerated depreciation were acceptable under the original regulation.

The different rates of depreciation may be illustrated through an example: Provider purchases, in 1967, a bed for use by Medicare patients at a cost of $1,000. The bed has an expected useful life of 10 years, at the end of which it will have an estimated salvage value of $100. The provider may allocate its cost among the next 10 years as follows:

Year	*Straight-Line*	*Double Declining Balance*	*Sum-of-the-years' digits*
1967	$90	$200	$164
1968	90	160	147

(Footnote continued on following page)

soon showed, however, that use of an accelerated method results in excessive payments to some providers. Therefore, on February 5, 1970, a proposed regulation was promulgated and then published in the Federal Register, 35 Fed. Reg. 2593, becoming effective on August 1, 1970, as 20 C.F.R. § 405.415. Under the new rule, nursing homes certified as Medicare providers after August 1, 1970, were not permitted to use an accelerated method, and presently certified homes were not allowed to use such method for any newly acquired assets. Providers were authorized to continue to depreciate on an accelerated basis those assets for which such method was already being used. But, if a provider terminated its participation in the program, or if the Medicare proportion of its allowable costs decreased substantially, the Secretary was now able to recover the amount by which the reimbursable cost that had been determined by using an accelerated depreciation method and paid to the provider exceeds the reimbursable cost which would have been determined and paid to it by using the straight-line method of depreciation. Such amount could be recouped as an offset to current reimbursement due the

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(Footnote continued from preceding page)

Year	*Straight-Line*	*Double Declining Balance*	*Sum-of-the-years' digits*
1969	90	128	135
1970	90	102	110
1971	90	82	98
1972	90	66	82
1973	90	52	66
1974	90	42	49
1975	90	34	33
1976	90	27	16

[figures rounded off to nearest dollar]

provider, or, if the home has left the program, as an overpayment.[3]

Subsequently, in May, 1972, the Provider Reimbursement Manual, which interprets and elaborates upon the Medicare regulations, was revised in a number of important respects. First, it announced that the new regulation regarding the recapture of accelerated depreciation would be applied retroactively to recover excess reimbursements received by providers during fiscal periods prior to 1970, the year of the new enactment. Second, the Manual made the recapture provision inapplicable to those providers that severed their relationship with the Medicare program effective before August 1, 1970. Third, the Manual explained that for purposes of the recapture rule, a substantial decrease in Medicare utilization occurs "where the provider's

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[3] Of particular relevance to this case is 20 C.F.R. § 405.514(d)(3), which reads:

> When a provider who has used an accelerated method of depreciation with respect to any of its assets terminates participation in the program, or where the health insurance proportion of its allowable costs decreases so that cumulatively substantially more depreciation was paid than would have been paid using the straight-line method of depreciation, the excess of reimbursables cost, determined by using accelerated depreciation methods and paid under the program over the reimbursable cost which would have been determined and paid under the program by using the straight-line method of depreciation will be recovered as an offset to current reimbursement due or, if the provider has terminated participation in the program, as an overpayment. In this determination of excess payment, recognition will be given to the effects the adjustment to straight-line depreciation would have on the return on equity capital and on the allowance in lieu of specific recognition of other costs in the respective years.

ratio of health insurance days to total in-patient days . . . has decreased 25 per cent or more from the base period to the computation period."[4] Because the Manual provisions enunciated HEW guidelines and policies for implementing the Medicare regulations but are not issued in accordance with the procedures specified in the Administrative Procedure Act,[5] they perforce must be considered interpretative rules.[6]

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[4] Section 136.4 of the Provider Reimbursement Manual (HIM-15), captioned, "Decrease in Health Insurance Proportion of Allowable Costs," states in part:

> B. *Amount of Decrease.*—A recovery of amounts paid in excess of straight-line depreciation is made where the provider's ratio of health insurance days to total inpatient days (certified areas only) has decreased 25 percent or more from the base period to the computation period. No recovery will be made, however, unless there has been a decrease of 25 percent or more in the overall average HI [Health Insurance] days in the base period and the HI days in the computation period. In addition, a recovery of amounts paid in excess of straight-line depreciation due to a decrease in HI utilization is not made where the cumulative total of HI days in the base period is less than 5 percent of the cumulative total of inpatient days in the facility (certified areas only).

[5] The Forward to the Manual describes its function as follows:

> This manual provides guidelines and policies to implement Medicare regulations. . . . The provisions of the law and the regulations are accurately reflected in this manual, but it does not have the effect of regulations. . . . The manual accommodates new pages or revisions as further interpretations of the regulations and changes in procedures and methods are made. Accordingly, revised sections, pages, or chapters are issued as necessary.

[6] *See* note 9 *infra.*

II.

The Center is a non-profit organization that owns and operates a skilled nursing facility in Clifton, New Jersey. Of the 244 beds that it maintains, 30 have been certified for use by Medicare patients. From the time it qualified as a provider in 1967, the Center has depreciated its capital assets on an accelerated basis. On November 17, 1975, the Hospital Service Plan of New Jersey, acting as HEW's fiscal intermediary,[7] notified the Center that an assessment would be made against it to recover $148,324.00. The assessment was based on a determination that the Center had a 47.36 per cent decrease in Medicare utilization between the base period, consisting of the years 1971 and 1972, and the computation period of 1973,[8] and represented the amount that could be recouped under the depreciation recapture regulation for the years 1967 through 1972.

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[7] The responsibilities of fiscal intermediary were subcontracted to Hospital Service Plan of New Jersey by Blue Cross Association, which held a contract to act as HEW's fiscal intermediary.

[8] Utilization of the Center's facilities during the periods ending December 31, 1971, 1972, and 1973 were as follows:

Year Ending	*Total Inpatient Days*	*Total Medicare Days*
December 31, 1971	10,230	3,412
December 31, 1972	10,472	3,066
December 31, 1973	10,410	1,715

Cumulatively, for the periods ending 1971 and 1972, the Center experienced a Medicare utilization of 31.29 percent. In 1973, the home's Medicare utilization dropped 16.47 percent. Thus, the Center's Medicare utilization dropped 47.36 percent between the base period of 1971-72 and the computation period of 1973.

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A hearing before the Provider Reimbursement Review Board was requested by the Center, and it was held on August 4, 1976. Noting that the regulation itself did not require retroactive recapture of accelerated depreciation, the Board expressed doubts whether the Manual's instruction that the provision be applied retroactively was valid inasmuch as it had not been promulgated in accordance with the rulemaking procedures of the Administrative Procedure Act.[9] The Board then found that, as the Center had contended, the decrease in Medicare utilization was no fault of the Center, but rather was caused by a June 1971 revision of HEW regulations that imposed stricter eligibility requirements for individuals seeking to qualify for Medicare coverage. Viewing the provision that changed the requirements for Medicare eligibility together with the provision authorizing the recapture of accelertaed depreciation, the Board concluded that "the result penalizes a provider for its decrease in Medicare utilization as if such decrease had been voluntary."[10] It held that the regulation regarding the recapture of accelerated depreciation should be applied only prospectively, and refused to allow the fiscal intermediary to recapture accelerated depreciation for periods ending on or before December 31, 1969.

[9] The Board questioned whether the Manual provisions constituted legislative rulemaking by HEW that did not comply with the procedures set forth in the Administrative Procedure Act, 5 U.S.C. § 553, or whether it was merely interpretative of the new regulation and was therefore not within the compass of that Act. We note that one respected commentator has stated that the agency's intent when issuing the rule should govern as to whether such rule is legislative or interpretative. Such intent is often to be determined from whether the agency followed the rulemaking procedures laid down in the Act or chose instead to issue the rule as an explanation of the agency's position regarding a matter within its purview. K. C. Davis, Administrative Law of the Seventies § 5.03 at 148 (1976). Accordingly, since HEW appears to have considered the Manual provision to be interpretative. *see* note 5 *supra,* we treat it as such.

[10] Appendix 6a.

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The Commissioner of Social Security examined the Review Board's decision on his own motion,[11] and revised that part of the decision that disallowed the recapture of accelerated depreciation for fiscal periods ending prior to January 1, 1970. The Center then filed suit in the District Court for the District of New Jersey, alleging that retroactive application of the depreciation recapture regulation (1) exceeds statutory authorization and (2) is unconstitutional.

On November 3, 1977, the district court granted summary judgment in favor of the defendants, thus sustaining the decision of the Commissioner. The trial judge interpreted 42 U.S.C. § 1395x(v)(1)(A)(ii), which directs that the regulations shall "provide for the making of suitable retroactive corrective adjustments," as authorizing the retroactive application of regulations such as the one in question. He also upheld the regulation and its retroactive application against constitutional attack, concluding that it is "reasonably related to the purposes of the enabling legislation"[12] because it ensures that the cost of providing services to non-Medicare patients will not be borne by the Medicare program. The Center's arguments that consideration be given to the fact that the Center is a non-profit

[11] Review was undertaken pursuant to 42 U.S.C. § 1395oo(f).

[12] *Citing* Mourning v. Family Publications Service, Inc., 411 U.S. 356, 369 (1973), *quoting* Thorpe v. Housing Authority, 393 U.S. 268, 280-81 (1969).

organization and that since it is continuing in the program the accelerated and straight-line methods of depreciation would eventually even out were deemed unpersuasive by the district court.

A timely appeal to this Court was filed by the Center, challenging (1) the statutory authorization for, and (2) the constitutionality of, the retroactive application of the recapture regulation.

III.

Our approach to the problems raised in this appeal differs to some degree from the position urged upon us by each of the litigants. It is evident that statutory authorization would exist for a depreciation recapture regulation that, by its terms, is to apply retroactively. Such authorization may be inferred from § 1395hh, which states that, "[t]he Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter." *See Adams Nursing Home of Williamstown, Inc.* v. *Mathews*, 548 F.2d 1077, 1082 (1st Cir. 1977). However, 20 C.F.R. § 405.415 itself is silent as to whether excess depreciation is to be recaptured for years prior to 1970, the year in which that regulation was promulgated. Instead, retroactive application of the regulation was decreed in a provision of the Provider Reimbursement Manual that was issued as an expression of the guidelines and policies that HEW was adopting to implement such regulation. The initial issue before us, then, is whether retroactive application to the Center of the depreciation recapture regulation is consistent with the purpose and design of that regulation.

Counsel for the defendants, as well as the dissent, insist that the Center must bear the burden of proving that such retroactive application is arbitrary and irrational. Such standard is said to be required by *Usery* v. *Turner Elkhorn Mining Co.*, 428 U.S. 1 (1976), where the Supreme Court, in upholding the Black Lung Benefits Act of 1972, 30 U.S.C. § 901 *et seq.*, against a due process challenge to the statute's retroactive impact, stated:

> It is by now well established that legislative Acts adjusting the burdens and benefits of economic life come to the Court with a presumption of constitutionality, and that the burden is on one complaining of a due process violation to establish that the legislature has acted in an arbitrary and irrational way.[13]

In our view, it would be improper to invest the administrative agency's retroactive modification at issue in the present case with a similar presumption of constitutionality. It is now well accepted that "courts do not substitute their social and economic beliefs for the judgment of legislative bodies, who are elected to pass laws,"[14] and that "[f]or protection against abuses by legislatures the people must resort to the polls, not to the courts."[15] The constitutional legitimacy that inheres in Congress by virtue of its accountability to the electorate is absent, how-

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[13] 428 U.S. at 15.

[14] Ferguson v. Skrupa, 372 U.S. 726, 730 (1963).

[15] Williamson v. Lee Optical of Oklahoma, Inc., 348 U.S. 483, 488 (1955), *quoting* Munn v. Illinois, 94 U.S. 113, 134 (1876).

ever, from the administrative process, and consequently, serious questions are continually being raised—and with increased frequency—regarding the legitimacy of the administrative appartus within the framework of American government.[16] Near the center of the growing concern over legitimacy lies the apprehension that the critical choices of our society will more and more be made by administrative personnel who ofttime are not, as a practical matter, accountable to anyone and whose decisions are immune from challenge.

It, is of course, open to speculation what repercussions such questioning may eventually have upon the standards that guide judicial review of various types of administrative promulgations.[17] For instance, to date courts generally have considered themselves bound by legislative rulemaking—rules promulgated pursuant to congressional delegation and in compliance with the procedural requirements of the Administrative Procedure Act—and have said they would overturn such rules only when they are not "reasonably related to the purposes of the enabling legis-

[16] For a treatment of the problem of the legitimacy of administrative agencies, *see generally*, J. O. Freedman, *Crisis and Legitimacy: The Administrative Process and American Government* (1978); K. C. Davis, *Discretionary Justice: A Preliminary Inquiry* (1969); Stewart, *The Reformation of American Administrative Law*, 88 Harv. L. Rev. 1667 (1975). A thoughtful discussion and evaluation of recent proposals for review of congressional delegations to administrative agencies is provided by Judge McGowan in McGowan, *Congress, Court and Control fo Delegated Power*, 77 Colum. L. Rev. 1119 (1977).

[17] *Cf.* Hampton v. Mow Sun Wong, 426 U.S. 88 (1976).

lation."[18] Such an accommodating standard of review has been justified on the ground that "[w]hen Congress has delegated to an agency the authority to make rules having [the] force of law and the agency uses the proper procedure to act reasonably and within the delegated power, the reviewing court has no more power to substitute [its] judgment for that of the reviewing agency than it has to substitute [its] judgment for that of Congress in determining the content of a statute."[19] Nonetheless, it appears that in recent years legislative rulemaking has been subjected to a more intensive level of judicial review than the reasonableness standard would suggest.[20]

For the purpose of this appeal, however, we need not anticipate future developments, since retroactive application to the Center of the depreciation recapture regulation was mandated solely by an interpretative rule found

[18] Mourning v. Family Publications Service, Inc., 411 U.S. 356, 369 (1973), *quoting* Thorpe v. Housing Authority, 393 U.S. 268, 280-81 (1969). *See also* Citizens to Preserve Overton Park v. Volpe, 401 U.S. 402, 416 (1971) (5 U.S.C. § 706(2) (A) "requires a finding that the actual choice made was not 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.' . . . [T]he ultimate standard of review is a narrow one.")

[19] K. C. Davis, Administrative Law of the Seventies § 29.01-1 at 205-06 (Cumulative Supplement 1977).

[20] *See, e.g.*, Tanners' Council of America, Inc. v. Train, 540 F.2d 1188 (4th Cir. 1976); Hooker Chemicals & Plastics Corp. v. Train, 537 F.2d 620 (2d Cir. 1976); National Welfare Rights Organization v. Mathews, 533 F.2d 637 (D.C. Cir. 1976); Automotive Parts & Accessories Ass'n v. Boyd, 407 F.2d 330 (D. C. Cir. 1968). *See generally*, K. C. Davis, *supra* note 24, at § 29.01-2.

in the Provider Reimbursement Manual. Interpretative rulemaking—those statements made by an agency to give guidance to its staff and affected parties as to how the agency intends to administer a statute or regulation—"are not controlling upon the courts"[21] inasmuch as they are not promulgated pursuant to a delegation by Congress of authority to legislate. Instead, courts remain free to substitute their judgment for that of the agency in determining how the statute or regulation is to be implemented. Describing the attitude with which courts regard interpretative rules, Justice Jackson commented in a famous passage that

> rulings, interpretations and opinions of the [responsible agency] . . ., while not controlling upon the courts by reason of their authority, do constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance. The weight of such a judgment in a particular case will depend upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control.[22]

In exercising our independent judgment whether the depreciation recapture regulation should be applied retro-

[21] United States v. Pennsylvania Industrial Chemical Corp., 411 U.S. 655, 674 (1973), *quoting* Skidmore v. Swift & Co., 323 U.S. 134, 140 (1944).

[22] Skidmore v. Swift & Co., 323 U.S. 134, 140 (1944). *See also* General Electric Co. v. Gilbert, 429 U.S. 125, 140-145 (1976). *See generally,* K.C. Davis, *supra,* note 24 at 29.01-1.

actively to the Center, as the Manual directs, we search in vain for a statement of the reasons that prompted the adoption of such an approach.[23] Moreover, the position

[23] We do not regard § 1395x(v)(1)(A)(ii), which is quoted in footnote 1 *supra,* as a specific direction to the Secretary of HEW to promulgate regulations that give retroactive effect to every change that is made in the methods and formulas for determining reasonable cost. Rather, that section appears to be an explicit instruction to the Secretary to promulgate regulations that mandate retroactive adjustments in the *payments* received by providers, so as to bring the amounts paid to them on the basis of their monthly estimates in line with the amount actually due them under the annual audit. In so instructing the Secretary, the section is designed to ensure the promulgation of regulations that would implement the scheme envisoned in § 1395g.

We recognize that our interpretation of § 1395x(v)(1)(A)(ii) is contrray to the construction given to it in Kingsbrook Jewish Medical Center v. Richardson, 486 F.2d 663 (2d Cir. 1973), and followed without further analysis by other courts. *See Summit Nursing Home, Inc.* v. *United States,* 572 F.2d 737 (Ct. Cl. 1978); *Springdale Convalescent Center* v. *Mathews,* 545 F.2d 943 (5th Cir. 1977); *Hazelwood Chronic & Convalescent Hospital, Inc.* v. *Weinberger,* 543 F.2d 703 (9th Cir. 1976), *vacated and remanded on other grounds,* 430 U.S. 952 (1977); *Kingsbrook Jewish Medical Center* v. *Richardson,* 486 F.2d 663 (2d Cir. 1973). However, *Kingsbrook* was a unique case. As does this case, most cases subsequent to *Kingsbrook* involved challenges to retroactively applicable regulations that were unfavorable to the provider, and the court in each case could have relied upon the general authorization of § 1395hh for its holding that the retroactively applicable regulation was statutorily authorized. *Kingsbrook,* in contrast, concerned the unusual situation of a provider that was seeking to compel the Secretary to apply retroactively a modification that benefited the provider, and therefore the court was forced to confront the issue whether any statutory provision *required* the Secretary to

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do so. In seizing upon § 1395x(v)(1)(A)(ii) to help the provider, the court in *Kingsbrook* rejected HEW's interpretation of that provision with the comment that, "[a]lthough we have uncovered no legislative history to elucidate this statutory language, its plain words do not require interpretative gymnastics." The court proceeded to infer from the language of sections 1395g and 1395x a "descriptive duality" between "methods of payment and methods of determining cost," and to assert that "[t]he regulations implementing these two sections follow the dichotomous statutory treatment." 486 U.S. at 669-70.

After examining various provisions throughout the Medicare statute with an eye toward the linguistic style employed, we remain unconvinced that Congress intentionally adopted different terminology in sections §§ 1395g and 1395x for the purpose of establishing the "descriptive duality" that the court in *Kingsbrook* infers from such usage. Nor do the regulations cited by that court reflect such "dichotomous statutory treatment." Most compelling to us, however, is a piece of legislative history that was not considered by the court in *Kingsbrook*. At one point, the Senate Committee on Finance considered a proposal that would have given providers an additional two percent above their allowable cost, to compensate for inaccuracies in the formulas used to determine reasonable cost. The following colloquy took place between Senator Anderson and Robert M. Ball, the Commissioner of Social Security:

> MR. BALL: We truly believe that the failure to allow the two percent would actually mean that we were paying less than the cost for these services.
> Senator ANDERSON: What does the law require?
> MR. BALL: That we pay cost.
> Senator ANDERSON: If you find out you haven't paid cost, you have to pay it then. Why don't you find out about it?
> MR. BALL: I don't think that the retroactive provision contemplates going back over the year and changing the principles. I think what is contemplated is that you pay first on

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taken by HEW in its Manual conflicts with the tenor of an earlier remark by the Commissioner of Social Security to the effect that it would be unfair to providers were HEW to make retroactive changes in the principles upon which "reasonable cost" is computed.[24] Finally, we note that the administrative agency here has no particular expertise concerning the issue of retroactivity. To the contrary, the extent to which retroactive effect may be given to a promulgation is governed by principles of law that have been developed and refined by the courts, primarily in the context of constitutional adjudication. Accordingly, we now examine such principles to determine whether the depreciation recapture regulation should be given retroactive effect in the present case. Because we shall conclude that retroactive application to the Center of the depreciation recapture regulation is incompatible with such principles, we shall exercise the prerogative that we have when re-

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> the basis of advances, that is estimates—not advances—on estimate.
> Senator ANDERSON: No, 'advance' is all right. I follow you.
> MR. BALL: We have changed that. That is not an advance. But you make an estimate at the beginning of the year based on these principles. Then at the end of the year you settle up, on the basis of the principles put out.
> It would hardly seem reasonable at the end of the year, after hospitals had entered into an agreement with you on the basis of certain principles, to shift all the principles for retroactive settlement in terms of how you compute a cost. I don't think that was contemplated at all.

Reimbursement Guidelines for Medicare, Hearings before the Senate Committee on Finance, 89th Cong. 2d Sess., 119 (1966).

[24] *See* note 23 *supra*.

viewing interpretative rules and refrain in the present case from giving the regulation the retroactive effect contemplated by the manual provision.

Retroactive measures—whether promulgated by a legislature or by an administrative agency—have traditionally been subjected to stricter scrutiny than have prospective measures.[25] Thus, as already mentioned, the validity of a prospective regulation by an administrative agency "will be sustained so long as it is 'reasonably related to the purposes of the enabling legislation.' "[26] In contrast, "courts have generally compared the public interest in the retroactive rule with the private interests that are overturned by it" in deciding whether to uphold a retroactive promulgation.[27] Such disparate treatment is justified because

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[25] *See, e.g.,* Usery v. Turner Elkhorn Mining Co., 428 U.S. 1, 16-17 (1976) ("It does not follow, however, that what Congress can legislate prospectively it can legislate retrospectively. The retrospective aspects of legislation, as well as the prospective aspects, must meet the test of due process, and the justifications for the latter may not suffice for the former.")

[26] Mourning v. Family Publications Service, Inc., 411 U.S. 356, 369 (1973), *quoting* Thorpe v. Housing Authority, 393 U.S. 268, 280-81 (1969).

[27] Adams Nursing Home of Williamstown, Inc. v. Mathews, 548 F.2d 1077, 1080 (1st Cir. 1977). *See also* SEC v. Chenery Corp., 332 U.S. 194, 203 (1947):

> [S]uch retroactivity must be balanced against the mischief of producing a result which is contrary to a statutory design or to legal and equitable principles. If that mischief is greater than the ill effect of the retroactive application of a

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retroactive laws interfere with the legally-induced and settled expectations of private parties to a greater extent than do prospective enactments. Still, retroactive rules designed to cure defects in regulatory schemes, such as the Medicare program, are often sustained because the "interest in the retroactive curing of such a defect in the administration of government outweighs the individual's interest in benefitting from the defect."[28]

The regulation permitting recapture of accelerated depreciation has been termed a curative measure, promulgated to correct an error or defect in the previous regulation.[29] Specifically, the Secretary perceived that the regulation as it originally stood facilitated abuse of the Medicare program by some providers. That regulation permitted a nursing home to choose between accelerated and straight-line methods for depreciating its assets. Al-

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> new standard, it is not the type of retroactivity which is condemned by law.

Although the language used by the Supreme Court to describe its approach to retroactive enactments has varied from case to case, the commentators have concluded that the common thread underlying the decisions has been the balancing of considerations on both sides of the issue. *See* Hochman, *The Supreme Court and the Constitutionality of Retroactive Legislation,* 73 Harv. L. Rev. 692 (1960); Slawson, *Constitutional and Legislative Considerations in Retroactive Lawmaking,* 48 Calif. L. Rev. 216 (1960).

[28] Hochman, *supra* note 27, at 705-06.

[29] *See, e.g.,* Springdale Convalescent Center v. Mathews, 545 F.2d 943, 956 (5th Cir. 1977).

though eventually, over the entire useful life of the asset, both methods would yield full reimbursement of cost to the provider, the amount received in any given year would vary in accordance with the method chosen. Under the straight-line method, a nursing home would recoup the identical sum during each year of the asset's useful life, while under either of the two accelerated methods it would recover as an item of cost a greater amount during earlier years than during later years.[30] Thus, if a provider cared for the same number of Medicare patients each year, under the straight-line method of depreciation, the cost of the asset attributable to each patient would be allocated evenly among the patients and recovered by the provider as it rendered the services. On the other hand, under an accelerated method of depreciation, part of the cost of caring for patients in later years would be charged to the Medicare program during the earlier years, even before the provider encountered those expenses.

Affording nursing homes the opportunity to depreciate their assets on an accelerated basis was considered necessary to encourage them to participate in the Medicare program. However, it also created a loophole, and permitted some providers to obtain undeserved windfalls. Such providers would opt to depreciate their assets on an accelerated basis, recovering from the program as a reimbursement for their costs amounts that they had not yet earned. But instead of remaining in the program and providing the care for which they had already been partially reimbursed, they would quit, pocketing more than their "reasonable cost," and, in effect, reducing their overhead costs of caring for private patients. Such a state of affairs could not be

[30] *See* note 2 *supra*.

countenanced in view of the explicit statutory directive that the regulations shall ensure that "the costs with respect to individuals not so covered [by Medicare] will not be borne by [Medicare] . . . ."[31] Accordingly, the Secretary promulgated 20 C.F.R. § 405.415(d)(3) in 1970, which authorized recapture of accelerated depreciation from providers that terminate their participation in the Medicare program or that experience a substantial decrease in Medicare utilization.

Prospective application of this curative measure must, of course, be sustained, because it is "reasonably related to the purposes of the enabling legislation." And with respect to such prospective application, the definition of substantial decrease in utilization that is offered in the Provider Reimbursement Manual reflects the considered judgment of the agency that was charged with administering the Medicare program and therefore, in the absence of any reason for being disregarded, commands judicial deference.

Similarly, *retroactive* application of § 405.415(d)(3) so as to recapture pre-1970 accelerated depreciation from providers that *terminate* their participation in the Medicare program after August 1, 1970—as is authorized by the Provider Reimbursement Manual—is reasonable, and accordingly, has been upheld by those courts of appeals that have passed on the question of its validity. *See Adams Nursing Home, Inc.* v. *Mathews*, 548 F.2d 1077 (1st Cir. 1977); *Springdale Convalescent Center* v. *Mathews*, 545 F.2d 943 (5th Cir. 1977); *Hazelwood Chronic & Convalescent Hospital, Inc.* v. *Weinberger*, 543 F.2d 703 (9th Cir. 1976), *va-*

[31] 42 U.S.C. § 1395x(v)(1)(A)(i).

cated and remanded on other grounds, 430 U.S. 952 (1977). These tribunals have wisely concluded that the public interest in recouping overpayments from homes that have left the Medicare program outweighs whatever disappointment has been caused to them. "When providers joined the program, they knew that 'small repairs' in the regulatory scheme were likely;"[32] indeed, the statute warned that they would be reimbursed only for "reasonable cost" and that retroactive adjustments might be necessary to ensure that no overpayments were made. Where a provider that had depreciated on an accelerated basis voluntarily leaves the program and will not in the foreseeable future care for any additional Medicare patients, it has undeniably been overpaid for its services. Not to collect the excess of accelerated depreciation over straight-line depreciation in such circumstances would be to permit a clear derogation from the public policy manifested in the legislative arrangement.

In opposition to such strong public interest stands the relatively weak private interest of the provider that voluntarily terminated its participation in the Medicare program. On the one hand, to the extent that a provider planned from the start to take advantage of the accelerated depreciation formula by dropping out of the program after being reimbursed in accordance with the higher rates available under such formula, the provider's expectation concededly was foiled by the recapture regulation. But "[w]hile such an expectation may not be wholly illegitimate, it would seem to have nothing to recommend it other than the traditional desire to take advantage of a loop-

[32] Adams Nursing Home of Williamstown, Inc. v. Mathews, 548 F.2d 1077, 1081 (1st Cir. 1978).

hole."[33] Assuming, on the other hand, that the provider left the program for nonsuspect reasons, it expected to be reimbursed only for its "reasonable cost," and consequently its expectation was not upset at all.

We may further accept, without deciding, that the public interest in recovering overpayments justifies the retroactive application of the depreciation recapture regulation to those providers that, though they have not formally ended their relationship with the Medicare program, have effectively achieved such a result by substantially decreasing to a nominal figure the proportion of Medicare patients under their care. Vindication of the public interest in curing defects in the regulatory scheme must not be hampered by such formalistic distinctions as whether the provider terminated its participation officially, or merely constructively.

Nevertheless, in our view, the balance between public and private interests shifts dramatically in the situation where the regulation is applied retroactively to recapture excess accelerated depreciation from a home in the Center's situation. When a provider continues to participate actively in the Medicare program, as the Center does, the public interest is forcing such a provider to change from an accelerated method to the straight-line formula is minimal, since there is no indication that such provider is taking undue advantage of the program. Even if the provider suffers a decline in Medicare patients during one or more years, it may well experience higher levels of utilization in subsequent years. In such event, the losses to the Medicare program from that one year will have been more than compensated for by the increased use of the facility during

[33] *Id.*

later years. Thus, only after Medicare utilization over the entire useful life of the asset is assessed can it be determined whether the provider has been overpaid for the services it actually rendered.

Indeed, the facts of the present case amply demonstrate this point. During the base period consisting of the years 1971 and 1972, the Center experienced a Medicare utilization of 31.29 percent. In 1973, its utilization was only 16.47 percent, a drop of 47.36 percent from the base period.[34] However, based upon figures adverted to by the Center and not disputed by the government, the Center's utilization by Medicare patients increased markedly in the two subsequent years, so that for the fiscal period ending December 31, 1975, its Medicare utilization was 41.89 percent.[35] Should this trend continue, the years of plenty may well make up for the lean years.[36]

Admittedly, there remains some marginal public interest in having the recapture regulation apply retroactively to a provider in the Center's position. Administrative convenience may suggest that once a substantial decline in utilization during any year indicates the possibility that an overpayment will eventually result, the Secretary need not wait for the useful life of the capital asset to elapse, but may recapture the excess accelerated depreciation immediately. Certainly this public interest—despite its relative insignificance—may justify prospective application of the

[34] *See* note 8 *supra.*

[35] During the year ending December 31, 1975, 4,342 days out of 10,365 total inpatient days were attributable to Medicare. Appellant's brief at 5.

[36] *Cf.* Genesis 41:30.

recapture regulation because it is reasonably related to the underlying legislative purpose; it cannot, however, support retroactive application of that provision in the face of the weighty, countervailing private interests affected here.

In a retroactivity challenge, such as the present one, a critical question is how the challenger's conduct, or the conduct of others in its class, would have differed if the rule in issue had applied from the start.[37] In the Center's case, that question may be answered with a degree of certainty. Had the Center been apprised in 1967, when it first joined the Medicare program, that upon choosing to depreciate its capital assets on an accelerated basis it also assumed the risk that should its utilization by Medicare patients substantially decrease in the future it would be vulnerable to recapture of the excess depreciation already taken, the Center undoubtedly would have opted for the straight-line method. The assumption by the Center of that formidable risk, whose fruition might well have a grievous effect on its cash flow and capital acquisition plans, probably would not have been warranted inasmuch as both methods of depreciation would in the end produce the same amount of reimbursement for its costs. But the Center was not so apprised, and drew up its financial plans upon the expectation that it may calculate the "reasonable cost" of its capital assets on an accelerated basis. When the "rules of the game" were suddenly modified, HEW claimed that the Center owed the Medicare program over $148,000. This severe impact upon the Center's finances, overturning its settled expectations, outweighs the

[37] *See Adams Nursing Home, supra,* at 1081. *See also* Usery v. Turner Elkhorn Mining Co., 428 U.S. 1, 17 & n.16 (1976); Slawson, *supra* note 27, at 225-26.

negligible public interest in applying the new provision retroactively to it.[38]

Our decision not to apply the recapture regulation retoactively in the present case is influenced by an additional factor: The Review Board found that the decrease in the Center's utilization by Medicare patients in 1973 was substantially related to the imposition in 1971 of more stringent requirements for eligibility for Medicare benefits. Inasmuch as the decline here was precipitated by governmental action rather than by any conduct on the part of the Center, it is hardly appropriate for HEW first to set up the cause and then to punish the provider for its consequences.

Our holding is a narrow one. We do not review the approach that was adopted by HEW to remedy a perceived abuse with the attitude that, "as a matter of constitutional law, a scheme more attuned to the equities of a particular provider's situation 'would have been wiser or more practical under the circumstances . . . .' "[39] Indeed, our decision leaves intact the objectives as well as the details of the curative measure conceived by HEW and enacted through legislative rulemaking as 20 C.F.R. § 405.415.[40] Rather, we address the limited issue whether such regula-

[38] *But see* Summit Nursing Home, Inc. v. United States, 572 F.2d 737 (Ct. Cl. 1978).

[39] *See* dissenting opinion at 26, *quoting* Usery v. Turner Elkhorn Mining Co., 428 U.S. 1, 19 (1976).

[40] In this respect, the present case differs from *Turner Elkhorn Mining*, where invalidation of the retroactive aspects of the 1972 Act would have struck at the heart of Congress' chosen approach for dealing with the problem before it. 428 U.S. at 18-19.

tion should be applied retroactively, as dictated by a subsequent modification of the Provider Reimbursement Manual which, because of its assertedly interpretative nature, was promulgated without complying with the safeguards of the Administrative Procedure Act. Not to consider that question would be to abdicate our responsibility to protect the public from arbitrary bureaucratic action, a responsibility that is manifested in the doctrine that permits courts to substitute their judgment for that of administrative agencies when they review interpretative rules. Moreover, in relying upon the accepted balancing test to determine that the regulation should not be applied retroactively to the Center, we assiduously avoid substituting our judgment for that of the administrative agency as to what changes would make the scheme "wiser or more practical;" we leave it to the Secretary to make that determination. We hold only that the agency may not, by an interpretative rule, rewrite a position it had taken previously, and upon which a party had justifiably and materially relied, under the pretext that such retroactive modification is integral to a curative measure, when such retroactivity is not supported by the rationale underlying the curative measure and when at least part of the cause for the party's noncompliance with the curative measure is attributable to the agency.

In view of the result we reach, we need not address the constitutional issue pressed by the Center, namely whether the retroactive application to it of the depreciation recapture regulation deprives it of property without due process of law.[41]

[41] *See, e.g.*, Dandridge v. Williams, 397 U.S. 471, 475-76 (1970) ("We consider the statutory question first, because if the appellees' position on this question is correct, there is no occasion to reach the constitutional issues"); Ashwander v. Tennessee Valley Authority, 297 U.S. 288, 346-48 (1936) (Brandeis, J., concurring).

Appendix B

IV.

The judgment of the district court will be reversed with respect to the recapture of the excess of accelerated depreciation over straight-line depreciation for fiscal periods ending on or before December 31, 1969. With respect to such recapture for fiscal periods ending after December 31, 1969, the judgment of the district court will be affirmed, and the cause will be remanded for proceedings consistent with this opinion.

SEITZ, *Chief Judge,* dissenting.

According to my best reading, the majority holds that HEW impermissibly interpreted 20 C.F.R. § 405.415(d)(3) as allowing the recapture of excess reimbursable depreciation paid before the effective date of that regulation in a case where the affected provider decreased his participation in the Medicare program by more than twenty-five percent after the adoption of that regulation. Because I believe that section 405.415(d)(3), on its face, calls for recapture of depreciation paid prior to its effective date and that the twenty-five-percent rule is a reasonable way to define the term "decrease" in that regulation, I dissent.

I differ with the majority about the source of the retroactivity in this case; I believe that a chronology of important events will illuminate our disagreement. The Center began its participation in the Medicare program in 1967. At that time it elected to use accelerated depreciation. In 1970, HEW banned the use of accelerated depreciation for assets acquired after August 1, 1970. In another regulation enacted at the same time, HEW announced that it would recapture any excess depreciation

Appendix B

paid to providers who terminated or constructively terminated their participation in the program:

> When a provider who has used an accelerated method of depreciation with respect to any of its assets terminates participation in the program, or where the health insurance proportion of it allowable costs decreases so that cumulatively substantially more depreciation was paid than would have been paid using the straight-line method of depreciation, the excess of reimbursable costs determined by using accelerated depreciation methods and paid under the program over the reimbursable cost which would have been determined and paid under the program using the straight-line method of depreciation will be recovered . . . .

20 C.F.R. § 405.415(d)(3) [presently codified at 42 C.F.R. § 405.415(d)(3)(i) (1977)]. In 1972, HEW issued a revised "Provider Reimbursement Manual" containing two items relevant to this case. First, according to the Manual, section 405.415(d)(3) was to be applied retroactively. Second, a decrease of twenty-five percent or more in a provider's "ratio of health insurance days to total inpatient days" would be deemed substantial enough to trigger the recapture of any excess depreciation. In 1973, the Center's participation fell below this twenty-five percent threshold. The Secretary subsequently attempted to recapture excess depreciation, as defined by section 405.415(d)(3), for each year since 1967.

I agree with the majority that the Secretary had statutory authority to adopt a regulation with retroactive effect. I cannot agree, however, that section 405.415(d)(3) required any subsequent administration gloss to make its

retroactive import clear; it had retroactive impact *ab initio*. Upon a provider's termination, HEW is entitled to recover "the excess of reimbursable cost determined by using accelerated depreciation methods *and paid under the program* over the reimbursable cost which would have been determined *and paid under the program* by using the straight-line method . . . ." [emphasis added] As later noted in the Manual, this provision does not reach providers who terminated before its effective date. But any provider who terminates after the effective date clearly is liable for the difference between the costs he had claimed using accelerated depreciation and the costs that he would have claimed had he used the straight-line method. This calculation is, by necessity, retrospective. A provider who terminated the day after this regulation became effective would be liable for overpayments for all prior years. No other reading of section 405.415(d)(3) makes sense.

Identifying the source of retroactivity is imperative here. The majority strikes down retroactive recovery from the Center because the Manual was an interpretative measure not promulgated under the Administrative Procedure Act. Two illustrations, however, demonstrate that retroactivity predated the interpretative Manual. First, if a provider had constructively terminated its participation—however the majority wishes to define that event—after 1970 but prior to the adoption of the twenty-five-percent rule in 1972, the Secretary could have invoked the plain terms of section 405.415(d)(3) and could have recovered all overpayments, including those preceding 1970. Second, if the Manual created any offensive retroactivity, then the Secretary should not be entitled to recover any depreciation accruing before 1972. Nevertheless, the majority allows the Secretary's recovery to date back to 1970, the effective date of section 405.415(d)(3), the true source of retroactivity in this case.

The majority, of course, is not "interpreting" section 405.415(d)(3) at all. Instead, it concludes that the twenty-five-percent rule is "fair" only when section 405.415(d)(3) is used to recover overpayments made after 1970. Presumably the majority would require a more significant decrease before allowing the Secretary to recover overpayments predating 1970. In rationalizing this unusual reading of the underlying regulation, the majority seems to invoke principles of estoppel. The Reimbursement Review Board did indeed assert that the government was partially responsible for the Center's predicament. The Commissioner of Social Security, however, contradicted this assertion when he reviewed the Board's decision; the district court affirmed the Commissioner's decision. The majority fails to give any explanation for rejecting the Commissioner's finding.

Turning to appellant's constitutional arguments, I believe that the correct standard of constitutional review for any authorized enactment, legislative or administrative, prospective or retrospective, is that stated by the Supreme Court in *Usery* v. *Turner Elkhorn Mining*, 428 U.S. 1, 15 (1976):

> . . . [L]egislative Acts adjusting the burdens and benefits of economic life come to the Court with a presumption of constitutionality, and . . . the burden is on one complaining of a due process violation to establish that the legislature has acted in an arbitrary and irrational way. . . .

See also, Springdale Convalescent Center v. *Mathews*, 545 F.2d 943 (5th Cir. 1977). Because the Center has not met

its burden of demonstrating that this regulatory scheme is not rationally related to the valid legislative purpose of ensuring that the agency's methods of cost reimbursement do not overcompensate providers for their services to Medicare patients, I would sustain retroactive application of this regulation. *See Summit Nursing Home, Inc.* v. *United States,* 572 F.2d 737 (Ct. Cl. 1978). In the words of the Supreme Court, a court may not say as a matter of constitutional law that a regulatory scheme more attuned to the equities of an individual provider's situation "would have been wiser or more practical under the circumstances. . . ." *Turner Elkhorn Mining, supra,* at 19.

I would affirm the judgment of the district court.

A True Copy:

Teste:

Clerk of the United States Court of Appeals for the Third Circuit

No. 79-92

In the Supreme Court of the United States

OCTOBER TERM, 1978

LINCOLN PARK NURSING HOME, ET AL., PETITIONERS

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

BRIEF FOR THE UNITED STATES IN OPPOSITION

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BRIEF FOR THE UNITED STATES IN OPPOSITION

OPINION BELOW

The decision of the United States Court of Claims (Pet. App. 1a-11a) is not yet reported.

JURISDICTION

The judgment of the Court of Claims was entered on April 20, 1979. The petition for a writ of certiorari was filed on July 18, 1979. The jurisdiction of this Court is invoked under 28 U.S.C. 1255(1).

QUESTION PRESENTED

Whether a regulation under the Medicare program that permits the Secretary of Health, Education, and Welfare to recover cost reimbursements paid to a nursing facility on an accelerated depreciation basis when the facility has experienced a substantial decline in the percentage of its Medicare patients is contrary to the Medicare Act or the Due Process Clause of the Fifth Amendment.

STATUTE AND REGULATION INVOLVED

42 U.S.C. 1395x(v)(1)(A) provides in pertinent part:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services * * *. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or serivces, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance

> programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

20 C.F.R. 405.415(d)(3), 35 Fed. Reg. 12331 (Aug. 1, 1970), provides:

> When a provider who has used an accelerated method of depreciation with respect to any of its assets terminates participation in the program, or where the health insurance proportion of its allowable costs decreases so that cumulatively substantially more depreciation was paid than would have been paid using the straight-line method of depreciation, the excess of reimbursable cost, determined by using accelerated depreciation methods and paid under the program over the reimbursable cost which would have been determined and paid under the program by using the straight-line method of depreciation will be recovered as an offset to current reimbursement due or, if the provider has terminated participation in the program, as an overpayment. In this determination of excess payment, recognition will be given to the effects the adjustment to straight-line depreciation would have on the return on equity capital and on the allowance in lieu of specific recognition of other costs in the respective years.

STATEMENT

The Medicare Act, 42 U.S.C. 1395 *et seq.*, provides for direct federal payments to nursing homes furnishing care to certain qualified patients. The statute directs the Secretary of Health, Education, and Welfare to reimburse homes for the "reasonable cost" of providing this service and provides that reasonable cost "shall be determined in accordance with regulations establishing the method or methods to be used * * *." 42 U.S.C. 1395x(v)(1)(A). The statute further requires (*ibid.*) that the regulations "provide for the making of suitable retroactive corrective adjustments where * * * the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive."

The Secretary's original regulations, which were published at 20 C.F.R. 405.415(a)(3) (1967), allowed reimbursement for the depreciation of capital assets by either of two methods: straight line depreciation (whereby the cost is prorated equally over the useful life of the asset) or accelerated depreciation (whereby the cost is heavily weighted in the initial period of an asset's useful life).

After several years' experience with the administration of the program, the Secretary found that the accelerated depreciation method permitted by the regulations was causing excessive payments to some providers. Accordingly, 20 C.F.R. 405.415(a)(3) was amended on August 1, 1970 (35 Fed. Reg. 12330) to require straight line depreciation for most new assets.[1] The amended regulation also contained a recapture provision, 20 C.F.R.

[1]The amended regulation continues to permit accelerated depreciation for (1) assets being depreciated on an accelerated basis prior to August 1, 1970, (2) assets for which the provider had made an application to change depreciation methods prior to August 1, 1970,

405.415(d)(3), which provides that when a provider who had used accelerated depreciation terminates participation in the program, or when the health insurance portion of its allowable costs decreases to the point that substantially more depreciation was paid than would have been paid using the straight-line method of depreciation, the difference between the depreciation that was paid and that which would have been paid using the straight-line method "will be recovered as an offset to current reimbursement due or, if the provider has terminated participation in the program, as an overpayment."

Petitioners have provided nursing services to the public since January 1, 1967. They participated in the Medicare program and, pursuant to the regulatory option initially permitted, were reimbursed for reasonable costs on the basis of accelerated depreciation. In 1974, HEW's fiscal intermediary determined (in a ruling constituting the final administrative decision; see Pet. App. 3a-4a) that from 1967 through 1971 petitioners received excessive reimbursement resulting from their use of accelerated depreciation and a substantial decrease in the percentage of their patients eligible under the Medicare Act (*id.* at 2a-4a).

Petitioners then filed suit in the Court of Claims to recover the costs attributable to the accelerated depreciation that had been disallowed.[2] The court granted the

(3) assets for which the provider had no option to use straight-line depreciation prior to August 1, 1970, (4) assets for which construction began prior to February 5, 1970, and (5) assets which the provider was bound by contract to purchase prior to February 5, 1970. See 20 C.F.R. 405.415(a)(3).

[2]Petitioners previously had filed suit in the United States District Court for the District of New Jersey, but that court held that it had no jurisdiction and dismissed the suit without prejudice to petitioners' right to bring another action in the Court of Claims. The court of appeals affirmed (Pet. App. 4a n.4).

government's motion for summary judgment, rejecting petitioners' claims that the recapture of reimbursements for accelerated depreciation for the years 1967-1970 is unconstitutional and contrary to the Medicare statute. Relying on its prior decision in *Summit Nursing Home* v. *United States*, 572 F. 2d 737 (Ct. Cl. 1978), the court held that the recapture of accelerated depreciation in this case was reasonable and consistent with the Secretary's express statutory obligation to recover excessive reimbursements and to ensure that the Medicare program not pay the costs of non-Medicare patients (Pet. App. 5a).

ARGUMENT

The decision of the Court of Claims is correct and does not warrant review by this Court. Moreover, the issue involved here is not of general or recurring importance, because the Secretary's recapture regulation concerns only the problems associated with the 1970 change in Medicare accounting from an accelerated depreciation system to a straight line depreciation system.

1. Petitioners claim (see Pet. 2) that applying the recapture regulation to reimbursements paid to them for accelerated depreciation before the recapture regulation was adopted is unconstitutional and contrary to the statutory design. These claims are insubstantial.

Petitioners' statutory argument is foreclosed by the express terms of the Medicare Act. 42 U.S.C. 1395x-(v)(1)(A) vests the Secretary with the responsibility for promulgating regulations governing Medicare cost accounting. It also requires the Secretary to ensure in those regulations that "the costs with respect to individuals [covered by the insurance programs established by this subchapter] will not be borne by such insurance programs" and to "provide for the making of suitable

retroactive corrective adjustments where * * * the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive" (emphasis supplied). Section 405.415(d)(3) was promulgated to carry out these directives. It is a reasonable means of accomplishing those ends and as such it is expressly authorized—indeed, mandated—by the statute.

As we have noted (see pages 4-5, *supra*), the regulations initially allowed providers to use accelerated depreciation. In 1970, however, the Secretary concluded that accelerated depreciation was not an appropriate method of Medicare accounting and prospectively barred its use (Pet. App. 4a-5a). The 1970 regulation also dealt with the transitional problem relating to providers who had already started to depreciate assets on an accelerated basis. The Secretary concluded that in general such providers would be permitted to continue to write off those assets using accelerated depreciation. See 20 C.F.R. 405.415(a)(3); note 1, *supra*. In cases where the ratio of a facility's Medicare to non-Medicare patients remains fairly constant, the high reimbursement in the initial years of the accelerated depreciation of assets allocable to Medicare patients is offset in later years by a countervailing low cost recovery for those assets, and the result in the long run is ordinarily much the same as with straight line depreciation. However, when the percentage of a facility's Medicare patients decreases substantially before the assets have been completely depreciated, use of accelerated depreciation allows the facility to obtain a

windfall.[3] The Secretary reasonably concluded that this result would be contrary to his statutory obligation not to permit the Medicare program to subsidize the costs of non-Medicare patients. See *Summit Nursing Home*, v. *United States*, 572 F. 2d 737, 744 (Ct. Cl. 1978).

Although petitioners appear to contend that application of the recapture regulation is unfair, they offer no arguments either disputing the Secretary's conclusion that the regulation reasonably operates to recover excessive reimbursements or supporting their claim that it is contrary to the statutory scheme. Moreover, petitioners entered the Medicare program on notice that the statute authorized and directed the Secretary to make "suitable retroactive adjustments" with respect to reimbursements that proved to be excessive.[4]

Similarly, there is no merit to petitioners' claim that application of the recapture regulation (and presumably the statute authorizing it) is unconstitutional. "[L]egislation readjusting rights and burdens is not unlawful solely because it upsets otherwise settled expectations." *Usery* v.

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[3]For example, suppose a facility purchased for a Medicare patient a bed with an estimated 10-year life and under some method of accelerated depreciation the Secretary reimbursed the facility for 70% of the cost of the bed in the first three years. If the bed were used by a Medicare patient for only the first three years and by a non-Medicare patient for the next seven years, the facility would receive and retain a disproportionate and excessive reimbursement for its Medicare-related costs in the absence of a recapture provision.

[4]Accord, *Adams Nursing Home* v. *Mathews*, 548 F. 2d 1077 (1st Cir. 1977); *Fairfax Nursing Center, Inc.* v. *Califano*, 590 F. 2d 1297 (4th Cir. 1979); *Springdale Convalescent Center* v. *Mathews*, 545 F. 2d 943 (5th Cir. 1977); *Hazelwood Chronic & Convalescent Hospital*, 543 F. 2d 703 (9th Cir. 1976), vacated on other grounds, 430 U.S. 952 (1977).

Turner Elkhorn Mining Co., 428 U.S. 1, 16 (1976). See, also *Fairfax Nursing Center, Inc.* v. *Califano*, 590 F. 2d 1297, 1302 (4th Cir. 1979); *Adams Nursing Home* v. *Mathews*, 548 F. 2d 1077, 1080-1083 (1st Cir. 1977). It was not improper for the Secretary to take steps, expressly authorized by statute, to limit their windfall recovery at public expense.

2. Petitioners rely primarily (Pet. 8-11) on *Daughters of Miriam Center For The Aged* v. *Mathews*, 590 F. 2d 1250 (3d Cir. 1978) (reproduced at Pet. App. 12a-46a), in which the court refused to apply the recapture regulation to a nursing home in circumstances somewhat similar to this case. Although we believe that *Daughters of Miriam Center* was wrongly decided, there are important differences between the two cases and the conflict, if any, is a narrow one of little continuing importance.

In *Daughters of Miriam Center*, the Secretary sought to recapture pre-1970 accelerated depreciation reimbursements because in several post-1970 years the home had experienced a substantial but temporary decline in the percentage of its Medicare patients as a result of the Secretary's having promulgated more stringent patient-eligibility requirements in 1971. The court of appeals, with one dissent, concluded that in those circumstances recapture of pre-1970 accelerated depreciation payments would not be sufficiently in furtherance of the purpose of the statute and regulation to outweigh what the court felt would be unfair prejudice to the home (Pet. App. 27a-41a), which had "justifiably and materially relied" on the prior regulation (*id.* at 41a). The court stressed, however, that its "holding is a narrow one" based on the particular facts of that case (*id.* at 40a). Thus, it agreed that recapture of pre-1970 accelerated depreciation reimbursements would be proper with respect to nursing homes that had completely terminated or voluntarily reduced their Medicare participation or that (unlike the

home in that case) did not subsequently increase their participation to previous levels (*id.* at 35a-38a). It also conceded that, even in the situation posed by the Daughters of Miriam Center, recapture served some public interest (*id.* at 38a). Finally, the court expressly declined to address the constitutional claims advanced by the nursing home (*id.* at 41a).

Although we believe that the Third Circuit erred in concluding that recapture was unfair in that case and improperly substituted its judgment for the Secretary's with respect to whether the regulation served the public interest, the decision (as noted above) was confined to its facts. Here, petitioners do not claim that their reduction in Medicare participation was only temporary or that it resulted from the 1971 change in patient-eligibility standards. Instead, they explain (Pet. 4-5) that the reduction resulted from difficulties they were experiencing with the fiscal intermediary, which apparently led petitioners to conclude that Medicare participation was not sufficiently remunerative. Hence, they would not be entitled to relief even under the Third Circuit's approach. In any event, the conflict, if any, between this case and *Daughters of Miriam Center* relates to a non-recurring problem arising from a change in Medicare accounting methods in 1970 and is not sufficiently important to warrant this Court's review.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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